

EXHIBIT B

Ex. 6 to First Kagan Decl. (ECF 13-6)

Ex. 14 to Second Kagan Decl. (ECF 14-14)


EmblemHealth®

PO Box 2814, New York, NY 10116-2814



1702

12/16/2016

WE WELCOME YOUR CALL

If you have any questions that this summary doesn't answer, please call us at **1-800-624-2414**, with your subscriber ID number. For other helpful information, visit us online at **www.emblemhealth.com**, where you can also elect to go paperless.


SUBSCRIBER NAME:
SUBSCRIBER ID NUMBER:
YOUR COVERAGE IS UNDERWRITTEN BY: GHI
SEE ENCLOSED INFORMATION ON APPEALING A CLAIM DECISION

Health Plan Payment Summary

THIS IS NOT A BILL. Your health care provider may bill you directly for any amount that you owe.

Summary of Claims

Amount billed	\$6,200.00	This is the amount your health care provider billed for services.
Amount allowed	\$751.00	The maximum amount we pay under your plan.
NYC catastrophic allowance	\$99.00	
What my plan paid	\$850.00	This is the amount EmblemHealth paid toward the bill.

PLEASE SEE CLAIM DETAILS ON THE FOLLOWING PAGE

Year-to-Date Information

2. For the plan year 2016, the remaining deductible for the patient is \$138.85. The remaining deductible for the family is \$0.00.

Important Message

This statement reflects services and items provided by a non-participating provider. You are responsible for services that are not covered by your benefit plan, such as charges for non-covered days or services and for any applicable copayment, coinsurance and/or deductible. You may also be responsible for paying the difference between what the non-participating provider charged and what we paid toward this claim.

We know you're busy. Here's a quicker, more convenient and secure way to receive your Explanations of Benefits: Go Paperless! Whenever we process a claim for you, we will send you an email letting you know you can view it in your secure personal page of emblemhealth.com. Just register at emblemhealth.com and choose "Go Paperless".